

**Erie County Department of Mental Health  
Centralized Housing Placement System  
Application for Supported Housing**

---

**Supported Housing** offers independent housing options for homeless and non-homeless individuals capable of maintaining an apartment with assistance from the housing provider. The Erie County Department of Mental Health (ECDMH) coordinates all referrals through a single point of entry for all OMH funded Supported Housing and HUD funded Homeless Supportive Housing Programs, known as the Centralized Housing Placement System (CHPS). Your timely submission of a complete and accurate referral packet will assist us in expediting an admission disposition decision. Applicants to the homeless programs must complete the Homeless Verification on pages 8 & 9. Non-homeless applicants need not complete these pages.

---

**Today's Date:** \_\_\_\_\_

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **M.I.** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Current Residential Status:** \_\_\_\_\_

**Person Completing Referral:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Name of Care Coordinator (if assigned):** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Residential Counselor (if assigned):** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Forward completed application to:**

**Erie County Housing Coordinator**

**Lake Shore Behavioral Health**

**430 Niagara St.**

**Buffalo, NY 14201**

**Phone: 856-9835 x25**

**Fax: 819-0030**

---

**FOR CHPS STAFF USE ONLY:**

**Date Application received:** \_\_\_\_\_

☐ Application accepted, assigned to: \_\_\_\_\_

**Date Assigned:** \_\_\_\_\_

**Date of Placement:** \_\_\_\_\_

☐ Application Declined due to: \_\_\_\_\_

**Notification made on** \_\_\_\_\_

---

**ECDMH CHPS SUPPORTED HOUSING APPLICATION  
Provider Selection Worksheet**

**Applicant's Name:** \_\_\_\_\_

**Complete Section A OR B**

**Section A:**

	<b>Consumer will accept first available opening regardless of housing provider</b>
--	--

**OR**

**Section B: Check Applicant's First, Second and Third Choices (Enter #1, #2 & #3 to the left of each selections)**

	<b>Transitional Services, Inc.</b> Homeless and Non-Homeless Programs 389 Elmwood Ave, Buffalo, New York 14222 Telephone: 874-8342 fax: 874-4429		<b>DePaul Community Services</b> Homeless and Non-Homeless Programs 1807 Elmwood Avenue, Suite 185 Buffalo, NY 14207 Telephone: 873-7482 fax: 873-8262
	<b>Buffalo Federation of Neighborhood Centers</b> Homeless and Non-Homeless Programs 97 Lemon St. Buffalo, New York 14202 Telephone: 852-5065 fax: 852-6270		<b>Southern Tier Environments for Living, Inc.</b> Homeless and Non-Homeless Programs 715 Central Avenue Dunkirk, New York 14048 Telephone: 366-3200 fax: 366-7840
	<b>Lake Shore Housing Program</b> Homeless Programs Only 951 Niagara St. Buffalo, New York 14213 Telephone: 856-9711 fax: 856-2863		<b>Housing Options Made Easy</b> Homeless and Non-Homeless Programs 75 Jamestown St., Gowanda, New York 14070 Telephone: 532-5508 fax: 532-5618
	<b>Restoration Society</b> Homeless Programs Only 175 Potomac Avenue Buffalo, New York 14213 Telephone: 886-3246 fax: 886-6803		<b>Spectrum Human Services</b> Homeless Programs Only 1280 Main St. 3 <sup>rd</sup> Floor Buffalo, New York 14209 Telephone: 832-1251 fax: 832-1271

**Contact Eric Weigel, Erie County Housing Coordinator, at 856-9835 ext. 25 for referral packets  
or access the Erie County Department of Mental Health website at  
[www.erie.gov/health/mentalhealth/](http://www.erie.gov/health/mentalhealth/)**

**Self-Referrals needing assistance should contact Marcie Kelley, 836-0822 extension 162, at The  
Mental Health Peer Connection.**

# ECDMH CHPS SUPPORTED HOUSING APPLICATION

## Risk/Financial Status Worksheet

Applicant's Name: \_\_\_\_\_

### Risk Assessment:

Is the consumer identified as high-risk, high-need due to any one of the following characteristics?

**YES    NO    DON'T KNOW**

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A history of sexually abusing others in the past five years   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A history of fire setting in the past five years  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A recent (last 12 months) indiscriminate serious assault (consumer arrested and/or victim required medical attention) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A history of homicide   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A history of recent (last 12 months) repeated episodes of serious self-harm requiring medical attention               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medical needs that cannot be addressed by the housing provider  |

If you answered yes to any of the above, please provide an explanation in the space provided below or include in the psychosocial history: (Attach additional pages as necessary)

---



---



---



---



---



---



---



---

### Financial Status:

- |   |            |                                   |           |
|---|------------|-----------------------------------|-----------|
| <input type="checkbox"/> Medicaid       | CIN# _____ | <input type="checkbox"/> Medicare | ID# _____ |
| <input type="checkbox"/> VA Medical Ins | ID# _____  | Other Insurance: _____            |           |

### Income Source (receiving or approved for)

- |   |               |  |               |
|---|---------------|--|---------------|
| <input type="checkbox"/> SSD            | Amount: _____ | <input type="checkbox"/> VA Benefits   | Amount: _____ |
| <input type="checkbox"/> SSI            | Amount: _____ | <input type="checkbox"/> TANF          | Amount: _____ |
| <input type="checkbox"/> Public Assist. | Amount: _____ | <input type="checkbox"/> Child Support | Amount: _____ |
| <input type="checkbox"/> Unemployment   | Amount: _____ | <input type="checkbox"/> Wages         | Amount: _____ |
| <input type="checkbox"/> Other Income   | Amount: _____ | <input type="checkbox"/> Other Income  | Amount: _____ |

### Current Financial Responsibilities (indicate amount in space provided):

- |                         |                         |
|-------------------------|-------------------------|
| Housing Costs: \$ _____ | Automobile: \$ _____    |
| Alimony: \$ _____       | Child Support: \$ _____ |
| Medical Exp.: \$ _____  | Loans: \$ _____         |
| Other: \$ _____         | Other: \$ _____         |

**ECDMH CHPS SUPPORTED HOUSING APPLICATION**  
**MEDICAL AND HEALTH INFORMATION**

**Applicant's Name:** \_\_\_\_\_

Date of most recent physical examination: \_\_\_\_\_ (attach copy if available)

**List all medical conditions and specific care instructions to be followed by the applicant.**

---

---

---

---

---

---

---

**Describe any physical conditions that will limit the applicant's mobility or their ability to live independently.**

---

---

---

---

---

**Additional Comments:**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

**ECDMH CHPS SUPPORTED HOUSING APPLICATION  
DISABILITY VERIFICATION**

**Applicant's Name:** \_\_\_\_\_ **Date of Referral:** \_\_\_\_\_

Primary Disabling Diagnosis		
Axis	Code	Diagnosis

To be considered an eligible adult with a mental disability, **all criteria in Section A must be met.** In addition, criteria in **B OR C** must be met. A signature from a **licensed/credentialed psychiatric or medical professional** trained to make this determination is required for placement consideration.

**A. Designated Disability**

- ☐ YES ☐ No The individual is 18 years of age or older and has a primary DSM-R psychiatric diagnosis other than primary alcohol/drug disorders, drug disorders, organic brain syndromes or developmental disabilities which is expected to be of a prolonged and indefinite duration AND substantially impedes the applicant's ability to live independently; **AND**
- ☐ YES ☐ No The applicant is medically/psychiatrically stable and poses no immediate potential likelihood of harm to self or others; **AND**
- ☐ YES ☐ No Is capable of maintaining a household and managing independent living (paying rent, meeting nutritional, medical and mental health needs) with housing case management and support provided;
- ☐ Monthly ☐ Weekly  
☐ Bi-weekly ☐ More than once a week

**AND B or C**

**B. Extended Impairment in Functioning due to Mental Illness**

The individual must meet **1** or **2** below:

**1.** The individual has experienced *two of the following four* functional limitations *due to a designated mental illness over the past 12 months* on a continuous or intermittent basis.

- ☐ YES ☐ No a. Marked difficulties in self-care
- ☐ YES ☐ No b. Marked restriction of activities of daily living
- ☐ YES ☐ No c. Marked difficulties in maintaining social functioning
- ☐ YES ☐ No d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home or school settings.

**OR**

- ☐ YES ☐ No **2.** The individual has met criteria for rating of *50 or less* on the Global Assessment of Functioning Scale.

**OR**

**C. Reliance on Psychiatric Treatment, Rehabilitation and Supports**

- ☐ YES ☐ No A documented history shows that the individual, at some prior time, met the threshold for B (above) but symptoms and/or functioning problems are currently attenuated by medication or other rehabilitation and supports and without these continued supports the individual would be unable to sustain independent community living.

Professional Staff Signature: \_\_\_\_\_  
(To be signed by a **licensed/credentialed psychiatric or medical professional**)

Date: \_\_\_\_\_

**ECDMH CHPS SUPPORTED HOUSING APPLICATION  
PRIORITY ELIGIBILITY WORKSHEET**

**SECTION A:**

**Check all that apply:**

\_\_\_ SPOE Enrollee: Applicant is currently enrolled (Skip Section B) with: \_\_\_ LSBH TCM \_\_\_ LSBH ACT \_\_\_ Spectrum ACT  
\_\_\_ AOT \_\_\_ BFNC New Options \_\_\_ Spectrum CCP \_\_\_ Spectrum MATS \_\_\_ Horizon  
\_\_\_ Eligible for Care Coordination Services but not currently enrolled (Complete Section B)  
\_\_\_ Not Eligible for Care Coordination and does not meet the criteria in Section B (skip Section B)

**SECTION B: Complete this section to help determine the applicant's eligibility for Care Coordination if not already enrolled.**

Individuals meeting any set of eligibility criteria below will be prioritized for placement in Supported Housing. Individuals **must** be **18 years of age or older** (exception of Young Adult Care Coordination; age 17-19) and have a **DSM-IV diagnosis of a severe and persistent mental illness (\*as defined by NYSOMH \*see Supplement III.)**. Review the following, as well as the ***Decision Guidelines***, to determine eligibility and level of care coordination services.

**TCM (TRANSITION CASE MANAGEMENT):** For individuals being released or discharged in Erie County from an Erie County Article 28 hospital, correctional setting, or associated with Mental Health Court or Probation; needs are acute, urgent, and can be managed within an approximate 6-month period. *If consumer does not meet specific criteria, a waiver may be requested (see below).*

**AT LEAST 2 UNMET URGENT NEEDS:**

\_\_\_ housing  
\_\_\_ entitlements (income, insurance)  
\_\_\_ outpatient treatment provider  
\_\_\_ health care (neglect and/or difficulty accessing)  
\_\_\_ support network

\_\_\_ difficulty following prescription medication regimen  
\_\_\_ difficulty with legal system;  
\_\_\_ failure of court dates, parole/probation violation  
\_\_\_ limited support network

**and**

**CHALLENGES IN AT LEAST 2 OF THE FOLLOWING AREAS:**

\_\_\_ ability to maintain stable housing  
\_\_\_ ability to attain/access entitlements  
\_\_\_ economic self-sufficiency  
\_\_\_ treatment/service linkage (mental health, substance abuse, and/or DD services)

**and**

**ANY COMBINATION OF 3 THE FOLLOWING WITHIN THE PREVIOUS 2 -YEAR PERIOD:**

\_\_\_ inpatient psych hospitalizations  
\_\_\_ arrests/forensic episodes  
\_\_\_ emergency contacts; Crisis Services, psych ER visits  
\_\_\_ ***number of total episodes***

***\*\*\* The following issues are disqualifiers for participation in Mental Health Court: Non-Erie County Resident, Mental Retardation Diagnosis, Violent Crime/History of Violence, Domestic Violence, Weapons Charges, Offense committed outside of Buffalo, Sex Offender, Narcotics Distribution, Functional Deficits too severe to utilize Court Program, Felony Offense, Incompetent.***

**ICM (New Options: Intensive Case Management), SCC (Spectrum Care Coordination):** For individuals whose needs are chronic in nature and require a more intensive level of services. *If individual does not meet specific criteria, a waiver may be requested (see below).*

\_\_\_ **AT LEAST 2 INPATIENT PSYCH/BEHAVIORAL ADMISSIONS WITHIN PAST 2 YEARS**

**and**

\_\_\_ **CHALLENGES IN AT LEAST 4 OF THE FOLLOWING AREAS:**

___ frequent arrests	___ difficulty following medication regimen
___ frequent ER/Crisis Services use	___ does not seek medical care
___ ability to maintain stable housing	___ difficulty with legal system; misses
___ ability to maintain/access entitlements	___ court dates, parole/probation violations
___ limited support network	___ economic self-sufficiency
___ treatment/ service linkage	___ ability to access rehabilitative
(mental health, substance abuse, DD services)	___ vocational, peer advocacy, social clubs

**ECDMH CHPS SUPPORTED HOUSING APPLICATION  
PRIORITY ELIGIBILITY WORKSHEET**

**WAIVER REQUEST:** Individual does not meet criteria. Waiver requested for the following reasons (EXPLAIN RATIONALE IN DETAIL):

---

---

---

**YACC (Young Adult Care Coordination)** – For young adults, ages 17-19, who require intensive assistance. Consumers referred to this program should be either young adults who are transitioning from the child mental health system to the adult system or have an emerging mental health diagnosis and are deemed to be at high risk for entering the mental health system for the first time. *If specific criteria unmet, a waiver may be requested (see waiver on previous page)*

\_\_\_ Age 17-19

**and**

\_\_\_ has a Severe Emotional Disturbance (SED) or Severe & Persistent Mental Illness (SPMI) diagnosis **and**

**At least one of the following:**

\_\_\_ History of multiple or extended psychiatric hospitalizations or institutional stays;

**or**

\_\_\_ History of involvement with multiple service systems (i.e., mental health, juvenile justice, Office of Children & Family Services, Social Services, etc.) due to a mental health condition;

**or**

\_\_\_ Acute, complex needs that may require intensive, comprehensive service coordination (i.e., housing, entitlements, outpatient linkages, vocational and/or educational needs, independent living skills)

**ACT (Assertive Community Treatment)**: For individuals who meet the ICM (previous page) criteria and whose needs are such that they can benefit from the services of a mobile, multidisciplinary mental health treatment team and has not benefited from traditional treatment and care coordination services. *If specific criteria unmet, a waiver may be requested (see waiver above)*

\_\_\_ ACT screening requested      Please explain rationale of need for this level of service:

---

---

**AOT (Assisted Outpatient Treatment)**: For individuals who meet the specific criteria under Kendra's Law, who may benefit from mandated services after other alternatives have been diligently attempted. An individual may be eligible for AOT if he/she: (*All must* apply, waiver is *not* applicable)

\_\_\_ is at least 18 years of age and has a mental illness \_\_\_\_\_

**and**

(most recent diagnosis & source)

\_\_\_ is unlikely to survive in the community without supervision, based on a clinical determination (specify)

**and**

\_\_\_ has a history of poor follow through with services for mental illness which has resulted in TWO psychiatric hospitalizations (or forensic incarcerations) within the preceding THREE years

**or**

\_\_\_ has a history of poor follow through with services that has resulted in at least ONE act of violence toward self or others, or threats of serious physical harm to self or others, within the preceding FOUR years

**and**

\_\_\_ is unlikely to accept treatment recommended (list the specific problems the person has had in following through that has contributed to hospitalization, incarceration, or violence to self/others

**and**

\_\_\_ is in need of AOT to avoid a relapse or deterioration which could lead to serious harm to self or others

**and**

\_\_\_ will likely benefit from AOT (specify) \_\_\_\_\_

**ECDMH CHPS SUPPORTED HOUSING APPLICATION  
HUD HOMELESS VERIFICATION  
(Required for applicants to HUD Homeless Programs Only)**

---

Applicant's Name: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

**Section A (at a minimum one of the criteria in section A must be met at the time of admission)**

☐ Yes ☐ No At the time of the referral and admission, lacks a fixed, regular and adequate night time residence and lives in one of the following:

- ☐ In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or the streets
- ☐ A supervised public or private emergency/temporary shelter (not transitional housing)
- ☐ Transitional/supportive housing program for homeless individuals or welfare hotels
- ☐ Hospital or other institution for thirty (30) days or less and was homeless upon admission to the hospital or other institution

**(Note for Housing Providers: The following criteria are not applicable to HUD grants initiated or starting renewal periods on or after 1/1/2006. After this date only Transitional Housing programs may use this criteria)**

- ☐ Facing eviction within one week (provide copy of eviction notice) and does not have the resources to obtain new housing
- ☐ Discharge within a week from an institution in which the person has been a resident for 30 or more consecutive days and no subsequent residence has been identified and he/she lacks the resources and support networks needed to obtain housing.
- ☐ Other homeless situation, describe:  
\_\_\_\_\_  
\_\_\_\_\_

**Section B. Chronic Homeless Determination**

☐ Yes ☐ No Is the individual Chronically Homeless as defined by the following:

- ☐ Is 18 years or old and is an unaccompanied homeless individual (a single person who is alone. The individual is not part of a homeless family and/or is not accompanied by a child or children)

**AND one of the following:**

- ☐ Has been continuously homeless via living in the streets or shelters for a year or more

**OR;**

- ☐ Has had at least 4 episodes of homelessness in the past three (3) years.

**NOTE:** Chronically Homeless disabled individuals must have resided on the street or in emergency shelter only (not transitional housing) during the stays prior to admission

Person Completing Form: \_\_\_\_\_

Date: \_\_\_\_\_

## ECDMH CHPS SUPPORTED HOUSING APPLICATION HUD HOMELESS VERIFICATION

Federally funded HUD Homeless programs require additional written verification of homelessness. Therefore, if the applicant is seeking admission to one of the homeless housing programs based on their current homelessness status, the referral source must attach the form of written documentation that is described below for the category of homelessness claimed by the applicant. Applicants for OMH/ECDMH funded non-homeless supported housing programs need not complete this verification.

**Written verification should be obtained from a reliable third party. Self-report statements are only acceptable if no other form of third party verification is obtainable.** Housing providers must insure that documentation reflects homeless status at the time of admission and therefore may need to update verification.

Verification is being provided that certifies the individual is homeless at the time of (check one):

☐ Referral Application

OR

☐ Admission

Check one	Category of Homelessness	Verification Required
	Living on street or other places not meant for human habitation	Signed and dated certification from an outreach worker or other third party verifying the individual resided on the street or other places not meant for human habitation immediately prior to admission
	Coming from an emergency shelter for homeless persons	Written referral from the emergency/temporary shelter verifying dates of stay immediately prior to admission
	Discharged from transitional or supportive housing for homeless individuals or welfare motels	Written verification including dates of program residency and homeless status prior to entry to the transitional/supportive program or welfare hotel
	Discharged from an institution with a length of stay of less than 31 days (i.e. hospital discharges)	Written verification of dates of stay from the institution staff verifying a length of stay less than 31 days immediately prior to this referral/housing admission, information on previous homelessness prior to the institution's admission, documentation of efforts to obtain alternative housing and lack of resources to obtain any other housing
<b>(Note for Housing Providers: The following criteria are <u>not applicable</u> to HUD grants initiated or starting renewal periods on or after 1/1/2006. After this date only Transitional Housing programs may use this criteria)</b>		
	Discharged from an institution with a length of stay of greater than 30 days	Written verification of dates of stay from the institution staff verifying a length of stay greater than 30 days immediately prior to this referral/housing admission, information on previous homelessness prior to the institution's admission, documentation of efforts to obtain alternative housing and lack of resources to obtain any other housing
	Person being evicted within 1-week	Written eviction from landlord or family and description of efforts to obtain alternative housing and lack of resources to obtain any other housing

**ERIE COUNTY DEPARTMENT OF MENTAL HEALTH  
CENTRALIZED HOUSING PLACEMENT SYSTEM  
SUPPORTED HOUSING APPLICATION CHECK LIST**

**Please utilize the provided checklist to ensure the Supported Housing referral application is complete and accurate. Incomplete applications will result in delays.**

- ☐ Housing Application Cover Page (page 1)
- ☐ Provider Selection Page (page 2)
- ☐ Risk/Financial Status Worksheet (page 3)
- ☐ Medical and Health Information (page 4)
- ☐ Disability Verification (page 5)
- ☐ Applicant Priority Eligibility Worksheet (page 6 & 7)
- ☐ Homelessness Verification (page 8 & 9)
- ☐ Application Checklist (page 10)
- ☐ Placement Report (page 11)
- ☐ Psychosocial History. *To include documentation regarding signs of decompensation and/or prodromal symptoms, risk behaviors, legal history, substance abuse, general health and personal & family history.*
- ☐ Copy of the referral agency consent for release of information.

**Forward Completed Application to:**

**Erie County Housing Coordinator  
Lake Shore Behavioral Health  
430 Niagara St.  
Buffalo, NY 14201**

**Phone: 856-9835 x25  
Fax: 819-0030**

**Erie County Department of Mental Health  
Centralized Housing Placement System  
Placement Report & Continued Stay Resource Request**

---

**(To be completed by Housing Provider upon placement and submitted to the Erie County Housing Coordinator)**

**APPLICANT NAME:** \_\_\_\_\_ **HOUSING PROVIDER:** \_\_\_\_\_

**PERSONS COMPLETING FORM:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**SCREENING DATE:** \_\_\_\_\_ **ADMISSION DATE:** \_\_\_\_\_

**CHECK 1 OR 2:**

1. ☐ **INITIAL RECOMMENDATIONS** (TO BE COMPLETED FOR ALL NEW CHPS ADMISSIONS CHECK ONE OF THE FOLLOWING THREE OPTIONS):

☐ Care Coordination and/or Housing Services are adequate and the applicant has been placed

☐ The applicant is in need of the additional resources identified below to finalize placement (Complete section #3 below).

**OR**

2. ☐ **Continued Stay Request** (Complete for current participants requiring added resources). The individual is already a participant and in need of additional supports/resources listed below to maintain placement.

---

**1. Additional Resource Request:**

<b>Applicant Need</b>	<b>Supports/Resources Requested</b>

**UPON PLACEMENT OR DETERMINATION FOR ADDITIONAL RESOURCES  
FAX COMPLETED FORM TO 819-0030. ATTENTION: ERIC WEIGEL**